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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Appellant,

—v.—

COMMONWEALTH OF VIRGINIA,
Appellee.

CITY OF AKRON, *et al.*,
Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, *et al.*,
Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, *et al.*,
Petitioners,

—v.—

CITY OF AKRON, *et al.*,
Respondents.

MOTION FOR LEAVE TO FILE AND BRIEF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, *AMICUS CURIAE*

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MOTION FOR LEAVE TO FILE

The American Public Health Association (APHA) hereby respectfully moves for leave to file the attached brief amicus curiae. Consent for the filing of this brief was obtained from the attorneys for Dr. Chris Simopoulos, the Akron Center for Reproductive Health, Inc., the City of Akron and Respondents Seguin and Black. The consent of the attorneys for the State of Virginia was requested but refused.

APHA is a national, nongovernmental organization established in 1872 with the objective of protecting and promoting personal and environmental health. APHA is the largest public health organization in the world, with a membership of

50,000, including fifty-one state and local affiliate organizations.

APHA was the first organization of health professionals in this country to recognize the detrimental consequences of illegality and inaccessibility of abortion to women. Prior to this Court's landmark rulings in 1973, and as early as 1968, APHA supported the principle that abortion should be a matter of choice for all women. Following the decisions of Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973) APHA urged their full implementation in every state in order to make abortion a matter of safe medical practice throughout the nation.

APHA has appeared as amicus in many other important health-related cases before this Court, including

Roe v. Wade, supra, Beal v. Doe, 432 U.S. 464 (1977) and Collautti v. Franklin, 439 U.S. 379 (1979). This Court extensively quoted APHA's "Standards for Abortion Services" in Roe v. Wade, 410 U.S. at 144-46. APHA has also appeared as amicus in numerous cases in federal and state courts, including at the District and Circuit Courts in Akron Center for Reproductive Health Care, Inc. v. City of Akron.

APHA's objective in the abortion field is to assure that safe abortion services are in fact readily accessible to all women, regardless of socio-economic status. It is APHA's position that second trimester abortions may be safely performed in qualified, non-hospital facilities. Based on that policy, and the medical

research which supports it, APHA believes that requirements of hospitalization for all second trimester abortions are not justifiable as necessary to preserve maternal health.

Because these cases raise important questions concerning state regulation of abortion services, amicus respectfully urges this Court to accept and file the enclosed brief amicus curiae.

Respectfully submitted,

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INTEREST OF AMICUS

The interest of amicus is set forth substantially in the foregoing motion. Amicus respectfully informs the Court that it is in full agreement with the discussion of issues contained in the brief filed by Planned Parenthood Federation of America in Akron Center for Reproductive Health Inc. v. City of Akron and Planned Parenthood of Kansas City Inc. v. Ashcroft. APHA has particular expertise and interest in the need for, cost of, and availability of heath care services, including abortion. Therefore, amicus submits this brief limited to the issue of second trimester hospitalization requirements and their effect on access to needed abortion services.

SUMMARY OF ARGUMENT

Abortion services are not available to every woman who needs them. Hospitals contribute to this unmet need by failing to offer abortion services, particularly second trimester abortions. Hospitalization requirements impose a burden on reproductive choice by restricting access to abortion and by making second trimester abortions more difficult and more costly to obtain. Teenagers suffer most from hospitalization requirements. Mature minors may effectively be denied the right, established by this court, to obtain a second trimester abortion without parental consent. Point IA-D.

Since 1973 medical knowledge and practice, evidenced by the policies and standards of the American Public Health Association and The American College of

Obstetricians and Gynecologists, has advanced to the point where second trimester abortions can be performed safely in clinics, with less delay and cost than in hospitals. Point IE.

Under previous rulings of this court including Roe v. Wade, 410 U.S. 113 (1973) Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) and Carey v. Population Services International, 431 U.S. 678 (1979) restrictions on abortion warrant strict judicial scrutiny. Point II.

ARGUMENT

I. STATE STATUTES AND LOCAL ORDINANCES WHICH REQUIRE ALL SECOND TRIMESTER ABORTIONS TO BE PERFORMED IN HOSPITALS SEVERELY RESTRICT ACCESS TO ABORTIONS SERVICES AND MAY ENDANGER WOMEN'S HEALTH.

A. There Is A Large Unmet Need For Second Trimester Abortion Services. Hospitalization Requirements Exacerbate That Need.

After this Court's decision of Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973), abortion became a legal medical procedure throughout the country. However, today, close to a decade after the decisions, abortion services are not available to every woman who needs them. The biggest area of unmet need is second trimester services. Hospitalization rquirements like those of Virginia and Akron, Ohio reduce the amount of second trimester services available to women.

Hospitals have not responded to this Court's decisions of Roe and Doe by integrat-

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ing abortion into their programs of health care services. In 1978 only 29% of all short-term, general, non-Catholic hospitals performed any abortions at all. Only 20% of those hospitals performed more than 30 procedures per year. Alan Guttmacher Institute, Abortion Needs and Services 1977-79 at 36 (1981) [Hereinafter cited as AGI Abortion Needs. Most Abortions are performed in specialized, non-hospital facilities known as "free standing clinics." In 1978 there were approximately 533 such clinics in the United States. F. Jaffe, B. Lindheim and P. Lee, Abortion Politics 35 (1981) [Hereinafter cited as Jaffe, Abortion Politics] However, hospitals are not abdicating abortion services in favor of these clinics. Most of the 1,728 public and 2,185 private hospitals which provided no abortion services in 1978 were located in non-metropolitan areas where there were no other abortion facilities available. AGI, Abortion Needs at 36.

Even fewer perform second trimester procedures and the number is declining.[1] In 1978 only 39% of the hospitals which provided any abortion services performed second trimester procedures. In that year only 635 hospitals performed second trimester procedures, 90 fewer than the estimated number in 1977. AGI, Abortion Needs at 58. In contrast, where not precluded by law, the number of free standing clinics that perform second trimester abortion services is increasing. Id.

The two states represented in the cases at bar provide graphic examples of the unmet need for second trimester services. As the Sixth Circuit found, in Akron, Ohio in 1977, only two hospitals performed any second trimester abortions, and in those two hospitals only nine second trimester procedures were

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[1] The vast majority of all abortions are performed in the first trimester of pregnancy. In 1978 only 9% of all abortions were performed more than 12 weeks after the onset of the last menstrual period. AGI, Abortion Needs at 13.

performed in the entire year. The estimated need for second trimester abortions in Akron was approximately 600 (10% of the 6000 women who sought abortions at Akron clinics.) Akron Center for Reproductive Health Inc. v. City of Akron, 651 F.2d 1198, 1209 (6th Cir. 1981) Similarly, in northern Virginia, the site of Dr. Simopoulos' practice, only two hospitals perform any second trimester abortions. Commonwealth v. Simopoulos, 221 Va. 1059 277 S.E. 2d 194, 204 (Va. 1981). Clearly, hospitals are not meeting the existing need for second trimester abortion services. Statutes and ordinances which limit the performance of second trimester abortions to hospitals will exacerbate the significant problem of unmet need.

The availability of second trimester abortion was an important factor in ruling on the constitutionality of second trimester restrictions in Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 78-79 (1976):

> Those unappreciated or overlooked factors [unavailability of prostaglandin method in Missouri] place the state's decision to bar the use of saline in a completely different light. The State, through §9 would prohibit the use of a method which the record shows is the one most commonly used nationally by physicians after the first trimester and which is safer, with respect to maternal mortality, than even continuation of the pregnancy until normal childbirth. Moreover, as a practical matter, it forces - woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed.
>
> As so viewed, particularly in the light of present unavailability - as demonstrated by the record - of the prostaglandin technique, the outright legislative proscription of saline fails as a reasonable regulation for the protection of maternal health. It comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting the vast majority of abortions after the first 12 weeks. As such, it does not withstand constitutional challenge.

As the Sixth Circuit recognized, when hospitals are the only source of second trimester abortion many women are unable to find services, or to pay for them, see Point I.B., infra. For these women there are three stark alternatives: carrying the

pregnancy to term, attempting self-abortions, or seeking an illegal abortion. Akron Center for Reproductive Health v. City of Akron, 651 F.2d at 1209. Each of these alternatives is more dangerous to the woman's health than second trimester abortion, the latter two far more dangerous.[2]

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[2] The experience of APHA members reveals that a significant percentage of women seeking second trimester abortions do so because of an identified threat to their lives of health such as pregnancy at a very young age or involving a fetus with known, serious congenital abnormalities or disease. Continuation of pregnancy for these women presents a heightened risk to their physical and psychological health, and the inability to obtain needed second trimester abortion services can be devastating. See, APHA Resolution 7907, "The Right to Second Trimester Abortion" (1979).

B. The Cost of In-Hospital Second Trimester Procedures Far Exceeds That of Non-Hospital Services.

The cost of abortion services in a hospital always exceeds the cost of parallel services in a clinic. In 1976 the average charge for an outpatient, first trimester abortion in a hospital was $250 plus the physician's fee. In-patient procedures were, of course, far more costly. In contrast, the average total cost of a first trimester procedure at a clinic at that time was $185-235. Jaffe, Abortion Politics at 36.

For second trimester abortion services the difference in cost is more pronounced.[3]

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[3] The Sixth Circuit noted testimony that the cost of a second trimester abortion in a hospital ($850 to 900) was more than double that of a second trimester abortion in a clinic ($350 to 400) Akron Center for Reproductive Health v. City of Akron, 651 F.2d at 1209.

C. Hospitalization Requirements Result in Delay in Obtaining Abortion Services, Which Has A Proven Negative Effect on Health.

Hospital abortions are characterized by added cost, limited geographic accessibility and added procedural complexities (e.g. scheduling the surgical facilities and the physician). These factors may delay a woman obtaining services. Delay is one of the most important factors in the risk of abortion morbidity. "Our findings clearly demonstrate that any delay increases the risk to a pregnant woman who wishes an abortion." W. Cates, K. Schulz, D. Grimes and C. Tyler, The Effect of Delay and Method Choice on the Risk of Abortion Morbidity, 9 Family Planning Perspectives 266, 268 (1977) [Hereinafter cites as Cates, et al., The Effect of Delay] (emphasis in the original). See also M. Bracken and S. Kasl, Delay in Seeking Induced Abortion:

A Review and Theoretical Analysis, 121 American Journal of Obstetrics And Gynecology 1008 (1975).

Legal abortion, including second trimester abortion is a remarkably safe procedure. See, e.g. W. Cates and D. Grimes, "Morbidity and Mortality of Abortion in the United States" in Abortion and Sterilization 155 (J. Hodgson, et. 1981) [Hereinafter cited as Cates and Grimes "Morbidity and Mortality"]. However, a decade of experience with legal abortion throughout the United States has confirmed that the earlier an abortion is performed, the less the risk of morbidity or mortality. "[D]elays of any sort--whether administrative, medical or social increase the risk of complication." Id. at 159; The Earlier the Safer Applies to All Abortions 10 Family Planning Perspectives 243 (1978); Cates, et al.,

The Effect of Delay at 267-68.

Thus, hospitalization regulations may have a significantly adverse effect on the health of even those women who are ultimately able to obtain second trimester abortions in hospitals.

D. Hospitalization Requirements Pose Particular Problems for Pregnant Teenagers.

For young women, the need for second trimester abortions is most acute, and the consequences of inaccessibility of those services is most severe.

1. Teenagers Have a Greater Need for Second Trimester Abortions.

This court has found previously that the number of teenage pregnancies have increased dramatically over the last twenty years, and that teenagers are disproportionately more likely to seek abortions. Michael M. v. Superior Court of Sonomoa

County, 450 U.S. 464, 470-71 (1981). See also, W. Cates, "Abortion for Teenagers" in Abortion and Sterilization 141 (J. Hodgson ed. 1981) [Hereinafter cited as Cates, "Abortion for Teenagers".] Teenagers are more likely than women in their 20's to need second trimester abortions. The younger the teenager, the greater incidence of second trimester abortion. "14 percent of abortions obtained by girls younger than 14 are performed at 16 weeks gestation or later, compared to just 7 percent of abortions among those aged 15-19 and 4 percent of abortion among women aged 20-24." Alan Guttmacher Institute, Teenage Pregnancy: The Problem That Hasn't Gone Away 55 (1981) [Hereinafter cited as AGI, Teenage Pregnancy] 52 percent of abortions obtained by girls under 14 are performed from 9 to 15 weeks gestation. Id.

The reasons teenagers often do not obtain abortions until midtrimester are varied. Lack of access to abortion services is a major cause. Id., L. Klein, Antecedents of Teenage Pregnancy 21 Clinical Obtetrics and Gynecology 1151, 1154 (1978); Cates, "Abortions for Teenagers" at 144. Another frequently cited factor in causing delay is the failure to recognize or suspect pregnancy, often due to a lack of understanding of the facts of reproduction. L. Klein, supra at 1154; Alan Guttmacher Institute, 11 Million Teenagers 30 (1976) [Hereinafter cited as AGI, 11 Million Teenagers.] For some young teenagers, irregular menstrual cycles make pregnancy detection difficult. AGI, Teenage Pregnancy at 56. In addition, many teenagers, faced with an unplanned pregnancy, and without the resources or skills of older women to cope with such a crisis,

psychologically deny the fact of pregnancy, often until anatomical changes are obvious, well into the second trimester. Cates, "Abortions for Teenagers" at 144. Given the obstacles teenagers face in pregnancy detection and obtaining abortion services, it is clear that teenagers will continue to need second trimester services:

> [T]he problem of late abortions, especially to teenagers, will not be significantly influenced by public health interventions. Thus, continued efforts are needed to make late abortion procedures safer, cheaper, more available, and more acceptable to women undergoing them.

Id. at 145

2. Hospitalization Requirements Create A Special Burden for Young Women.

The three consequences of hospitalization requirements--added cost, travel and delay--are particularly burdensome for teenagers. The methods of fundraising available to most teenagers are unlikely

to be sufficient to raise the $800 to 1,000 needed for an in-patient second trimester abortion. The lack of Medicaid funds for abortion in most states further complicates a teenager's problem. Most teenagers are dependent on their parents, partners, or public funds to pay for their abortions. See M. Hanson, Abortion in Teenagers, 21 Clinical Obstetrics and Gynecology 1175, 1179 (1978) (Young teenagers try to earn money for abortion through babysitting, resulting in delay.)

Research indicates that "the farther a woman has to travel to obtain an abortion, the less likely she is to have one." J. Shelton, E. Brann and K. Schultz, Abortion Utilization: Does Travel Distance Matter? 8 Family Planning Perspectives 260, 262 (1976). In that study, the effect of travel distance was most pronounced for black teenagers. Id. For young teenagers,

arranging travel outside one's own community is particularly difficult. The cost of travel adds further to the extremely high cost of obtaining second trimester abortions.

Since a large number of teenagers do not seek abortion services until well into the second trimester, further delay resulting from the limited availability of hospital services or hospital procedures will have the effect of advancing the abortion into a stage of significantly greater risk and for some, preclude abortion altogether.

3. The Consequences of Being Unable to Obtain a Second Trimester Abortion are Devastating to Teenagers.

Unintended pregnancy is frequently a severe physical, psychological and emotional crisis in the life of a teenager. "There are few situations in which denying a minor the right to make an

important decision will have consequences so grave and indellible." Bellotti v. Baird, 443 U.S. 622, 642 (1979). The gravity is equal when a teenager is unable, by reason of a state or local law to effectuate that decision.

For teenagers abortion, including second trimester abortion is safer than childbirth. "Teenagers have a lower death-to-case rate than older women after a legally induced abortion", even accounting for the disproportionate number of second trimester procedures obtained by teenagers. Cates, Abortions for Teenagers at 146. The risk of death from pregnancy continuation for teenagers is at least five times that of pregnancy termination. Id.

Teenagers, especially young teenagers, are at great risk in pregnancy. Fatal complications of pregnancy are 60 percent more likely for a girl under 15 than for a

woman 20-24, and 13 percent more likely between the ages of 15 and 19. AGI, 11 Million Teenagers at 23; L. Tryer, Complications of Teenage Pregnancy, 21 Clinical Obstetrics and Gynecology 1135 (1978). "Studies have shown that teenagers have a greater incidence of toxemia, abrupto placentae and cephalopelvic disproportion in pregnancy." G. Ryan and J. Schneider, Teenage Obstetric Complications, 21 Clinical Obstetrics and Gynecology 1191 (1978).[4]

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[4] Amicus does not suggest that all teenage pregnancies ought to be terminated. "Recent studies indicate that good prenatal care and attention to the psychosocial and economic problems of pregnancy reduced perinatal death and complication rates for pregnant teenagers." G. Ryan and J. Schneider, supra, at 1191. For those teenagers who wanted but could not obtain second trimester abortion services such good prenatal care and concern is not likely. In addition, the stress of the unwanted pregnancy and inability to obtain an abortion add further physical and psychological risk to the pregnancy.

(footnote continued)

4. Hospitalization Requirements May Have the Effect of Denying Minors the Right to Obtain Abortion Without Parental Consent.

In addition to the burdens on access caused by the cost, travel and delay, hospitalization requirements may pose an acute problem of constitutional dimensions for minor women--the inability to obtain an abortion without parental consent. It is not unusual for hospitals, like those of Northern Virginia, not to admit or treat minor women without parental consent.[5]

(footnote continued)

It is inevitable, therefore, that teenagers who are unable to obtain second trimester abortions will have pregnancies marked by a much heightened risk of health damage or death.

[5] Amicus does not address in this brief the validity of direct parental notice or consent statutes or provisions such as Secs. 1870.05(A) and 1870.05(B) of the "Akron Ordinance."

This court has recognized that minors as well as adults are protected by the Constitution, specifically that they enjoy a right of privacy. In Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 74 (1976) this court held that a state could not lawfully authorize an absolute parental veto over the decision of a minor to terminate her pregnancy. After the Danforth decision, this court has examined a number of statutes relating to minors and abortion. The court has held that states which seek to require parental consent for abortion "must provide an alternative procedure whereby authorization for the abortion can be obtained without first consulting a parent." Bellotti v. Baird, 443 U.S. 622, 643 (1979) Further, in such procedures if a "pregnant minor shows (1) that she is mature enough and well enough informed to make her abortion

decision in consultation with her physician independently of her parents wishes or (2) that even if she is not able to make this decision independently, that the desired abortion would be in her best interests" 443 U.S. at 643-44, the minor's choice must be effected.

In Bellotti v. Baird, 443 U.S. at 642 this court stated:

> The abortion decision differs in important ways from other decisions that may be made during minority. The need to preserve the constitutional right and the unique nature of the abortion decision, especially when made by a minor, require a state to act with particular sensitivity when it legislates to foster parental involvement in this matter.

Even if it would be permissible or appropriate to require parental consent for all other medical or surgical procedures in a hospital, "the unique nature and consequences of the abortion decision make it inappropriate" to allow such blanket consent

requirements. Bellotti v. Baird, 443 U.S. at 643.

This court has recognized that "many parents hold strong views on the subject of abortion and young, pregnant minors, especially those living at home, are particularly vulnerable to their parents' efforts to obstruct both an abortion and their access to court." Bellotti v. Baird, 443 U.S. at 647 Clearly the same holds true when a minor needs access to a hospital for a second trimester abortion.

By refusing to consent to hospital admission parents could exercise an absolute veto over a minor's decision to terminate a pregnancy in the second trimester. Hospitalization regulations like the ones at issue would have the effect of doing indirectly what this court has repeatedly held a state may not do

directly--require all minors to obtain parental consent prior to obtaining a second trimester abortion. Planned Parenthood of Central Missouri v. Danforth, supra; Belloti v. Baird, supra. See also H. L. v. Matheson, 450 U.S. 398 (1981).

E. Recent Evidence From Medical Associations Finds That Hospitalization Requirements Are Not Justifiable as Necessary for the Preservation of Maternal Health.

As noted by this court in Roe v. Wade, 410 U.S. at 145, in 1970, APHA's first Recommendations on Abortion Services contained a recommendation that second trimester procedures be performed in hospitals. That recommendation was based on the limited research available, which was in turn based on the limited number of legal abortions performed in the 1960's. In 1979 APHA revised its position that all second trimester abortions should

be done in hospitals on an in-patient basis. This change is reflected in the APHA Resolution 7907, "The Right to Second Trimester Abortion" (Adopted November 1979).

Recently the American College of Obstetricians and Gynecologists (ACOG) revised its 1974 Manual of Standards and approved the performance of early second trimester abortions in clinics' 1982 ACOG Manual of Standards. These policy revisions are based on research and practice subsequent to 1973, and thus were not available to either APHA or to this Court at the time Roe v. Wade, supra, and Doe v. Bolton, supra, were decided.[6]

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[6] The City of Akron has relied heavily on the 1974 ACOG standard throughout this litigation, in an attempt to satisfy its burden, as defined by this court in Planned Parenthood of Central

(footnote continued)

In Roe v. Wade, 410 U.S. at 163 this court recognized that permissible state regulation of abortion to protect maternal health must be measured "in the light of present medical knowledge." This recognition of the advancing state of medical knowledge, treatment, and practice in the field of pregnancy is critical to the consideration of challenges to second trimester hospitalization requirements.

(footnote continued)

Missouri v. Danforth, 428 U.S. 52, 77-78, n.12 (1976). That burden requires Akron as the proponent of a restriction on access to establish facts which would show that the hospitalization requirement is sufficiently related to the state's legitimate interest in women's health. Akron Center for Reproductive Health v. City of Akron, 651 F.2d 1198, 1208 (6th Cir. 1981)

Up-to-date medical data from APHA and ACOG has informed this court's decisions in previous cases, particularly on the issues of abortion safety and the relative risks of childbirth and abortion. See Roe v. Wade, 410 U.S. at 163, Planned Parenthood of Central Missouri v. Danforth, 428 U.S. at 76-9.

While there are no published studies presently available that compare the safety of hospital and non-hospital abortions in the second trimester, the U.S. Department of Health and Human Services (formerly the Department of Health, Education and Welfare) has researched the comparative risk of death for hospital and non-hospital abortions at twelve weeks or less. This study revealed no major differences between the risks of death in the two types of institutions. D. Grimes et al., Comparative Risk of Death from Legally Induced Abortion in Hospital

and Non-Hospital Facilities, U.S. Department of Health, Education and Welfare, Center for Disease Control (1980). The results of this study have significance for midtrimester procedures in that the causes of death or complications for second trimester abortions are similar to those for first trimester abortions. If non-hospital facilities, therefore, meet adequate minimum standards[6] for dealing with the complications which may occur with second trimester abortions, there is no longer any reason to believe that the hospital setting is safer.

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[6] Amicus supports the National Abortion Federation and Planned Parenthood standards for non-hospital abortion facilities as constituting "minimum standards."

As Dr. Willard Cates, an expert on the medical consequences of abortion and childbirth, and for a number of years the head of the Abortion Surveillance Unit of the Center for Disease Control stated in connection with the formulation of APHA policy:

> I do not favor any proposed legislation limiting abortions performed after 12 weeks' gestation to hospital in-patients. Rather, experienced clinicians should be allowed to cautiously raise the gestational age threshold for abortions performed in free standing clinics. This will serve to minimize the inconvenience and costs of the procedure, and in some instances, will increase the availability of legal abortion who would be denied such services if it was required that they be performed in hospitals.

(Letter from Dr. Willard Cates to Dr. William McBeath, Executive Director, APHA, January 19, 1979).

Medical evidence is growing and consistent that second trimester procedures can be performed in clinics more safely

with less delay and less cost than previously. Each of these factors has a significant correlation to maternal health. Statutes and ordinances, like the ones at issue require that all second trimester procedures be performed in more expensive, less accessible hospitals. As such, they fly in the face of the policies of medical associations, and the body of medical fact which informs those policies.

II. THE COURT MUST EXAMINE THESE REGULATIONS WITH STRICT SCRUTINY BECAUSE THEY IMPOSE A RESTRICTION ON A FUNDAMENTAL RIGHT.

Amicus submits that the statute and ordinance at issue in these cases warrant strict judicial scrutiny because of the important constitutional right involved. In Roe v. Wade, 410 U.S. 113 (1973), this court held that in the second trimester the state may have a

compelling interest in protecting health which justifies regulations to promote maternal health. This ruling was predicated on the Court's finding that, at that time, 1973, second trimester abortions were as dangerous as childbirth

> With respect to the State's important and legitimate interest in the health of the mother, the "compelling" point, in the light of present medical knowledge, is at approximately the end of the first trimester. This is so because of the now established medical fact, ... that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Roe v. Wade, 410 U.S. at 163. (emphasis added)

Because advances in the abortion field have made the procedures safer than childbirth, it is the position of amicus that there is no longer the same reason

for second trimester regulations. Assuming arguendo, however, that the state may lawfully regulate second trimester abortions, the regulation at issue must fall under the standards set by this court in Roe v. Wade, supra, Planned Parenthood of Central Missouri v. Danforth, supra, and subsequent decisions. In Planned Parenthood this court specifically addressed the question of whether a Missouri second trimester restriction on saline abortions, the method then most commonly used in the second trimester was in fact "reasonably related to maternal health", and concluded that, far from promoting a woman's health, the restriction "forc[ed] a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." 428 U.S. at 79.

Medical evidence amassed since 1976 strongly indicates that blanket hospitalization requirements for second trimester abortions have the same effect, by prohibiting earlier, safe, less expensive second trimester abortions in clinics.

Amicus urges this court to make its own analysis of the medical evidence as it has done in the past, in judging whether in light of current medical facts, a hospitalization requirement for all second trimester abortions is reasonably related to maternal health. See Planned Parenthood of Central Missouri v. Danforth, 428 U.S. at 77.

In Carey v. Population Services International, 431 U.S. 678 (1979) this court clearly stated that regulations which impede access to a reproductive right are to be judged under the same strict standard as those regulations

which prohibit the exercise of the right entirely:

> the same test must be applied to regulations that burden an individual's right to decide to prevent conception or terminate pregnancy by substantially limiting access to the means of effectuating that decision as is applied to statutes that prohibit the decision entirely.

431 U.S. at 688.

III. THE STATUTE AND ORDINANCE SINGLE OUT ABORTION FOR DIFFERENT TREATMENT IN MEDICAL REGULATION.

Second trimester abortion is the only procedure which the state of Virginia requires to be done in a hospital. Similarly, no medical procedure other than second trimester abortion is the subject of an Akron ordinance limiting performance to a hospital. These regulations, by prohibiting a medical practice, i.e. second trimester abortion in a clinic, which may be safer than the medical practice presecribed by the regulation, i.e. second trimester abortion in a hospital, unnecessarily and unwisely constrain physicians' exercise of their best medical judgment. This court has recognized that the physician's judgment is a strong safeguard of maternal health. See Doe v. Bolton, 410 U.S.

at 192, 195, 197; Planned Parenthood of Central Missouri v. Danforth, 428 U.S. at 77-79.

APHA policy recognizes that second trimester abortions, like the issue of Medicaid funding for abortions, is a favorite target of those who are politically opposed to abortion. APHA Policy No. 7907 "The Right to Second Trimester Abortion" (1979). Statutes and ordinances which single out abortion for unreasonable and unwarranted regulation dissuade doctors from performing abortion.[8] Further, such unwarranted and unreasonable restrictions have the effect of stigmatizing doctors who do perform second trimester abortions. As a consequence, fewer

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8 The experience of the restriction of federal funds for abortion is illustrative of the response by doctors

(footnote continued)

doctors will perform second trimester abortions, thus further limiting the availability of needed abortion services. Given the special risks of pregnancy in the Medicaid eligible population, particularly among teenagers (see Point I.D, supra), Amicus strongly believes that the number of abortions which would have qualified for federal funding would have exceeded 1% of the previous total.

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and hospitals to politically motivated administrative restrictions on medical treatment. The Hyde Amendment prohibited Medicaid payment for abortions not necessary to save the life of the mother. The Hyde Amendment did not prohibit the performance of abortions. See Harris v. McRae, 448 U.S. 297 (1980). After the Hyde Amendment went into effect, less than 1% of the abortions previously performed for Medicaid eligible women were performed and submitted for funding. W. Cates The Hyde Amendment in Action, 246 Journal of the American Medical Association 1109 (1981).

Amicus suggests that, throughout the country, in those states not funding either voluntarily or under court order, doctors are simply refusing to perform or consider abortions for Medicaid elegible women due to the bureaucratic trouble of certification procedures and the fear that their certifications would receive extra-ordinary and unwarranted scrutiny by state or federal authorities.

CONCLUSION

For the foregoing reasons, the Court should hold that state statutes and local ordinances that require

hospitalization for all second trimester abortions are unconstitutional.

Respectfully submitted,

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